NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 19-095

IN THE MATTER

OF

GURPREET BAJWA, M.D.

COMMISSIONER'S ORDER OF SUMMARY ACTION

TO: GURPREET BAJWA, M.D.
[redacted]

The undersigned, Sally Dreslin, M.S., R.N., Executive Deputy Commissioner of Health, pursuant to N.Y. Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, Virginia Board of Medicine, has made a finding substantially equivalent to a finding that the practice of medicine by GURPREET BAJWA, M.D. (the Respondent), New York license number 224792, in that jurisdiction constitutes an imminent danger to the health of its people, as is more fully set forth in the "Order of Summary Suspension" (henceforth: "predicate action"), attached hereto as Appendix "A" and made a part hereof.

It is therefore:

ORDERED, pursuant to N.Y. Public Health Law §230(12)(b), that effective immediately, Respondent shall not practice medicine in the State of New York, or practice in any setting under the authority of Respondent's New York license.

Any practice of medicine in violation of this Order shall constitute Professional Misconduct within the meaning of N.Y. Educ. Law §6530(29) and may constitute unauthorized medical practice, a Felony defined by N.Y. Educ. Law §6512.

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty days after the final conclusion of the disciplinary proceeding in the predicate action. The hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Hearing or Notice of Referral Proceeding to be provided to the Respondent after the final conclusion of the proceeding in the predicate action.

Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

Respondent shall notify the Director of the Office of Professional Medical Conduct, New York State Department of Health, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719 via Certified Mail, Return Receipt Requested, of the final conclusion of the proceeding in the predicate action, immediately upon such conclusion.

THE NEW YORK PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 18, 2019

[redacted]

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner of Health
New York State Department of Health

Inquiries should be directed to:

Pooja Rawal
Senior Attorney
New York State Health Department
Bureau of Professional Medical Conduct
Corning Tower, Room 2512
Albany, NY, 12237
Phone: 518-473-4282[redacted]

APPENDIX "A"

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: **GURPREET SINGH BAJWA, M.D.**
License Number: 0101-231157
Case Numbers: 179293, 183815, 185731, 188025, 188150, 188390, 188862, 190106, 190210, 191665, 191694

ORDER OF SUMMARY SUSPENSION

Pursuant to Virginia Code § 54.1-2408.1(A), a quorum of the Board of Medicine ("Board") met by telephone conference call on April 5, 2019, after a good faith effort to convene a regular meeting of the Board had failed. The purpose of the meeting was to receive and act upon information indicating that Gurpreet Singh Bajwa, M.D., may have violated certain laws relating to the practice of medicine in the Commonwealth of Virginia, as more fully set forth in the "Notice of Formal Administrative Hearing and Statement of Allegations," which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under Virginia Code § 54.1-2408.1(A), the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the license of Gurpreet Singh Bajwa, M.D., to practice Medicine and Surgery in the Commonwealth of Virginia is SUSPENDED. It is further ORDERED that a hearing be convened within a reasonable time of the date of entry of this Order to receive and act upon evidence in this matter.

Pursuant to Virginia Code § 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD

[redacted]

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED AND MAILED ON: 4/5/19

BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: **GURPREET SINGH BAJWA, M.D.**
License Number: 0101-231157
Issue Date: November 1, 2001
Suspension Date: April 5, 2019
Case Numbers: 179293, 183815, 185731, 188025, 188150, 188390, 188862, 190106, 190210, 191665, 191694

NOTICE OF FORMAL ADMINISTRATIVE HEARING AND STATEMENT OF ALLEGATIONS

You are hereby notified that a Formal Hearing has been scheduled before the Board of Medicine ("Board") regarding your license to practice Medicine and Surgery in the Commonwealth of Virginia.

TYPE OF PROCEEDING:	This is a formal administrative hearing before a panel of the Board.
DATE AND TIME:	**May 17, 2019** **10:00 A.M.**
PLACE:	Virginia Department of Health Professions Perimeter Center - 9960 Mayland Drive 2nd Floor - Virginia Conference Center Henrico, Virginia 23233

LEGAL AUTHORITY AND JURISDICTION:

1. This formal hearing is being held pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11). This proceeding will be convened as a public meeting pursuant to Virginia Code § 2.2-3700.

2. At the conclusion of the proceeding, the Board is authorized to take any of the following actions:

- Exonerate you;
- Reprimand you;
- Require you to pay a monetary penalty;
- Place you on probation and/or under terms and conditions;
- Continue your license on suspension;
- Revoke your license.

ABSENCE OF RESPONDENT AND RESPONDENT'S COUNSEL:

If you and/or your counsel fail to appear at the formal hearing, the Board may proceed to hear this matter in your absence and may take any of the actions outlined above.

RESPONDENT'S LEGAL RIGHTS:

You have the right to the information on which the Board will rely in making its decision, to be represented by counsel at this proceeding, to subpoena witnesses and/or documents, and to present relevant evidence on your behalf.

COMMONWEALTH'S EXHIBITS:

Enclosed is a copy of the Commonwealth's exhibits that will be distributed to the members of the Board for their review unless an objection is received within the timeframe specified in Section III below and sustained by the Panel Chair or acting Board officer. **These documents are enclosed only with the notice sent by UPS. Please bring these documents with you to the formal hearing.**

FILING DEADLINES:

If you want to submit evidence or use expert witnesses, below are the deadlines for the submission of such evidence or your expert witness list. The deadlines for filing objections, if any, to the exhibits and expert witness list also follow.

I. Exhibit Submission	DEADLINE DATE
Respondent's Submission of Documents for Evidence (including expert witness reports) (Submit 15 copies to Jennie F. Wood, Discipline Case Manager)	April 19, 2019
Commonwealth's Deadline to Respond to Respondent's Submission (Addressed to Jennifer L. Deschenes, Deputy Executive Director)	April 25, 2019
Respondent's Deadline to Respond to Commonwealth's Objection (Addressed to Jennifer L. Deschenes, Deputy Executive Director)	April 30, 2019

II. Expert Witness Identification	DEADLINE DATE
Respondent's Expert Witnesses (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	April 19, 2019
Commonwealth's Deadline to Object to Expert Witness (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	April 25, 2019

III. Objections to Commonwealth's Exhibits	DEADLINE DATE
Respondent's Objections to Commonwealth's Exhibits (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	April 19, 2019

Commonwealth's Response to Respondent's Objections (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	**April 25, 2019**

NOTE: If no objections have been received by April 19, 2019, the exhibits will be distributed to the Board members for their review.

IV. Motions/Continuance Requests	**DEADLINE DATE**
Respondent's Motions (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	**April 19, 2019**
Commonwealth's Response to Motions (Submit, in writing, to Jennifer L. Deschenes, Deputy Executive Director)	**April 25, 2019**

STATEMENT OF ALLEGATIONS

The Board alleges that:

1. At all times relevant hereto, Gurpreet Singh Bajwa, M.D., was licensed to practice Medicine and Surgery in the Commonwealth of Virginia.

2. In spite of a November 30, 2012 Consent Order suspending Dr. Bajwa's license based on findings that he excessively prescribed controlled substances in a dangerous manner likely to harm patients and the public and maintained deficient medical records, and notwithstanding Dr. Bajwa's completion of continuing medical education in the proper prescribing of controlled substances and medical recordkeeping pursuant to the Consent Order, Dr. Bajwa violated Virginia Code §§ 54.1-2915(A)(3), (12), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A); 18 VAC 85-20-26(C) of the Board's Regulations Governing the Practice of Medicine (Board's General Regulations); and the Board's Regulations Governing the Prescribing of Opioids and Buprenorphine (*effective for conduct on or after March 15, 2017*) (Board's Prescribing Regulations) with regard to his care and treatment of Patients A, B, and C from approximately January 2017 through August 2018. Specifically:

a. Regarding Patient A, a then 23-year-old female:

i. Dr. Bajwa began prescribing Patient A benzodiazepines at her first office visit on August 5, 2017, based solely on the patient's self-report of anxiety and neuropathy without conducting a comprehensive physical examination, documentation of symptoms or findings supporting a therapeutic purpose, or formulating a diagnosis.

ii. In spite of checking Patient A's Prescription Monitoring Program (PMP) report for the patient's medication history at the first office visit on August 5, 2017, which showed that Patient A received a 30-day supply of alprazolam (C-IV) 2mg #60 on July 24, 2017, Dr. Bajwa nonetheless

prescribed an additional 30-day supply of alprazolam 2mg #60 and gabapentin (C-VI) 300mg #90. As a result, Patient A obtained #120 dosage units of alprazolam 2mg in a two-week period, or 8mg/day, a dose double the manufacturer's recommended daily maximum of 4mg/day.

iii. Although the patient's August 5, 2017, PMP report also indicated that in the approximate six-weeks prior to the visit Patient A filled prescriptions for Suboxone (a narcotic used for the maintenance and treatment of opioid dependence), clonazepam (a C-IV benzodiazepine), and eszopiclone (a C-IV sedative-hypnotic), Dr. Bajwa failed to verify Patient A's substance use and mental health history. Had Dr. Bajwa done so, he would have learned that Patient A had a lengthy history of anxiety, depression, addiction and substance misuse, including heroin, cocaine, PCP, benzodiazepines, and alcohol abuse, as demonstrated by the following:

- Hospitalizations in October 2015 and December 2015 at Fairfax Hospital for seizures secondary to benzodiazepine withdrawal.
- Fairfax Hospital emergency department visits on March 23, 2017; April 27, 2017; May 17, 2017; and May 26, 2017, complaining of drug withdrawal and requesting benzodiazepines and detox.
- Multiple admissions (October 15, 2014; December 28, 2014; May 26, 2017; and June 12, 2017) to the Fairfax Hospital Comprehensive Addiction Treatment Services (CATS) for detox, Suboxone maintenance, and rehabilitation.
- Documented history of combining alcohol with benzodiazepines and opiates; doctor shopping; not taking medications as prescribed; and discharges from physician practices for non-compliance with treatment.

iv. Although Patient A's PMP report indicated that four different providers prescribed clonazepam 1mg to Patient A between January and July 2017, on August 21, 2017, Dr. Bajwa doubled the strength and prescribed Patient A clonazepam 2mg #60 (30-day supply) without documenting any therapeutic need to do so in the medical record.

v. On September 19, 2017, December 29, 2017, January 17, 2018, January 18, 2018, February 18, 2018, April 12, 2018, May 3, 2018, and July 2, 2018, Dr. Bajwa prescribed carisoprodol (C-IV) 350 mg to Patient A when the patient did not present to the office for an examination or evaluation to

determine the therapeutic need for such medication and without any documented diagnosis warranting such prescriptions.

vi. On August 28, 2017, Dr. Bajwa prescribed Patient A hydrocodone/acetaminophen (C-II) 10/325mg #30 (15-day supply), and on March 22, 2018, he prescribed tramadol (C-IV) 50mg #14 (seven-day supply), while failing to satisfy provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to do the following:

- Document having considered nonpharmacologic and non-opioid treatment for Patient A's complaints of pain, as required by 18 VAC 85-21-30(A).
- Perform a history and physical examination appropriate to the complaint and also failed to conduct an assessment of the patient's history and risk of substance misuse, as required by 18 VAC 85-21-30(B).
- Prescribe Naloxone to Patient A as required when concomitant benzodiazepine use is present, as required by 18 VAC 85-21-40(B)(3).
- Document the extenuating circumstances justifying co-prescribing hydrocodone/acetaminophen and tramadol with benzodiazepines and other sedative-hypnotics, as required by 18 VAC 85-21-40(C).
- Document a tapering plan to achieve the lowest possible effective doses when co-prescribing hydrocodone/acetaminophen and tramadol with benzodiazepines, sedative-hypnotics, and carisoprodol, as required by 18 VAC 85-21-40(C).
- Document a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, and a treatment plan when he prescribed hydrocodone/acetaminophen and tramadol to Patient A, as required by 18 VAC 85-21-50.

vii. Although Dr. Bajwa prescribed multiple controlled substances with high abuse potential to Patient A, he failed to monitor and manage the patient's use of such medications, and continued prescribing to Patient A when he knew or should have known that Patient A was exhibiting signs and symptoms of addiction and medication overuse/misuse. Specifically:

- Dr. Bajwa regularly authorized prescriptions for controlled substances prior to the time Patient A should have needed more had she taken the medications as prescribed, as follows:

Date Written	Drug/Dose	Quantity	Days Supply	Date Last Prescription/Days Supply
8/5/17	alprazolam 2mg	60	30	7/24/17 30 day supply
8/8/17	alprazolam 2mg	30	10	8/5/17 30 day supply
8/28/17	zolpidem 10mg	30	30	8/8/17 30 day supply
8/28/17	alprazolam 2mg	60	20	8/5/17 30 day supply
8/28/17	alprazolam 2mg	40	14	8/5/17 30 day supply
8/28/17	gabapentin 600mg (prior strength 300mg)	120	30	8/5/17 30 day supply
9/19/17	zolpidem 10mg	5	5	8/28/17 30 day supply
9/19/17	zolpidem 10mg	10	10	8/28/17 30 day supply
9/29/17	carisoprodol 350mg	14	7	9/19/17 15 day supply
9/29/17	zolpidem 10mg	10	10	9/19/17 15 day supply
10/16/17	clonazepam 2mg	60	30	10/13/17 7 day supply
10/16/17	eszopiclone 3mg	30	30	10/13/17 7 day supply
12/29/17	carisoprodol 350mg	20	10	12/22/17 15 day supply
12/29/17	alprazolam 2mg	12	4	12/22/17 15 day supply
1/2/18	eszopiclone 3mg	30	40	12/22/17 15 day supply
1/2/18	carisoprodol 350mg	60	30	12/29/17 10 day supply
1/17/18	carisoprodol 350mg	60	30	1/2/18 30 day supply
1/18/18	carisoprodol 350mg	60	30	1/17/18 30 day supply
2/28/18	alprazolam 2mg	90	30	2/13/18 30 day supply
3/22/18	alprazolam 2mg	15	5	2/28/18 30 day supply
3/22/18	alprazolam 2mg	33	11	2/28/18 30 day supply
3/22/18	alprazolam 2mg	42	14	2/28/18 30 day supply
4/12/18	carisoprodol 350mg	90	30	3/22/18 30 day supply
5/3/18	carisoprodol 350mg	90	30	4/12/18 30 day supply
5/23/18	carisoprodol 350mg	3	1	5/9/18 30 day supply
5/23/18	alprazolam 2mg	90	30	5/5/18 31 day supply
6/13/18	alprazolam 2mg	90	30	5/23/18 30 day supply

- In spite of Patient A's approximate two-month absence from Dr. Bajwa's practice prior to the patient's December 22, 2017, office visit (due to the patient's attempt at another detox/rehab via the inpatient/outpatient CATS program), and although Dr. Bajwa checked Patient A's PMP report on December 18, 2017, prior to the visit, and thus knew Patient A was prescribed Suboxone by another provider while absent from his practice, Dr. Bajwa failed to consult with the Suboxone prescriber to coordinate Patient A's care, or document having done so, and did not request medical records connected to the patient's Suboxone therapy.

- In spite of the significant risk of central nervous system depression when Suboxone is taken with benzodiazepines, other sedative-hypnotics, and muscle relaxants, Dr. Bajwa nonetheless resumed prescribing alprazolam, eszopiclone, and carisoprodol at Patient A's December 22, 2017, office visit.

- On April 4, 2018, Patient A was taken to Inova Fair Oaks Hospital via EMS with a suspected poly-substance overdose requiring ventilator support. EMS reported that Patient A was found with an empty bottle of alprazolam, and bottles of Suboxone, clonazepam,

Phenergan, Lexapro, catapres, vistaril, gabapentin, and Lunesta (eszopiclone). After reviewing Patient A's PMP report and noting the prescriptions from Dr. Bajwa, Patient A's treating physician called Dr. Bajwa to discuss Patient A's condition, and documented that Dr. Bajwa took her phone number but never called her back. In spite of actual notice of Patient A's overdose, Dr. Bajwa nonetheless immediately resumed prescribing benzodiazepines, other sedative-hypnotics, a muscle relaxant, and a stimulant to Patient A as follows:

Date Written	Filled	Medication/Dose	Quantity	Days Supply
4/12/18	4/13/18	zolpidem 10mg	15	15
4/12/18	4/16/18	zolpidem 10mg	15	15
4/12/18	4/13/18	clonazepam 2mg	30	15
4/12/18	4/13/18	carisoprodol 350mg	90	30
4/23/18	4/23/18	alprazolam 2mg	45	15
4/23/18	4/23/18	methylphenidate ER 18 mg	30	30
4/23/18	4/23/18	eszopiclone 3 mg	5	5
4/23/18	4/27/18	eszopiclone 3 mg	4	4
4/23/18	4/28/18	eszopiclone 3 mg	21	21

- On April 28, 2018, Patient A was admitted to Fairfax Hospital with another benzodiazepine overdose. The treating physician noted Patient A's years' long history of drug misuse and overdoses, particularly with benzodiazepines, her overdose risk score of 950/999, and the quantity of benzodiazepines Patient A had received in the prior month from Dr. Bajwa and others. Based on the provider's assesament and "concern for death related to OD when she is released," this physician notified Dr. Bajwa of Patient A's overdose on or about April 28, 2018. In spite of notification of a second benzodiazepine overdose in less than a month, Dr. Bajwa promptly continued prescribing Patient A benzodiazepines and muscle relaxants as set forth below:

Date Written	Filled	Medication/Dose	Quantity	Days Supply
5/3/18	5/4/18	carisoprodol 350mg	90	30
5/5/18	5/9/18	gabapentin 600 mg	90	30
5/5/18	5/5/18	alprazolam 2mg	20	7
5/5/18	5/7/18	alprazolam 2mg	45	15
5/5/18	5/8/18	alprazolam 2mg	25	9
5/9/18	5/9/18	temazepam (C-IV) 30mg	30	30
5/9/18	5/9/18	carisoprodol 250 mg	108	30
5/9/18	5/9/18	carisoprodol 250 mg	12	3
5/9/18	5/9/18	carisoprodol 250 mg	18	30

- Patient A was again admitted to Fairfax Hospital on May 12, 2018, after overdosing on carisoprodol, admitted to CATS on May 13, 2018, for inpatient detox, and transitioned to outpatient treatment on May 21, 2018. Patient A was discharged from the program on May 24, 2018, after presenting to her daily outpatient CATS program with slurred speech,

ameared make-up, and admitting that she had filled prescriptions written the day before by Dr. Bajwa for alprazolam 2mg #90, carisoprodol 350mg #3, zolpidem 10mg #15, and triazolam (C-IV) 0.25mg #10 prior to presenting to CATS.

- On May 28, 2018, Patient A was admitted to Fair Oaks Hospital with her fourth poly-substance overdose in approximately a month, and again required ventilator support. She was discharged home on June 5, 2018, with an alprazolam taper and information regarding community resources because no inpatient facility would accept her transfer.

- In spite of Dr. Bajwa's knowledge of Patient A's abuse of the medications he prescribed, Dr. Bajwa continued prescribing Patient A multiple benzodiazepines, other sedative-hypnotics, and muscle relaxants through August 2018 as follows:

Date Written	Date Filled	Medication/Dose	Quantity	Days Supply
6/6/18	6/6/18	temazepam 30mg	15	30
6/13/18	6/27/18	eszopiclone 3 mg	30	30
6/13/18	6/18/18	alprazolam 2mg	30	10
6/13/18	6/22/18	alprazolam 2mg	60	20
6/14/18	6/14/18	diazepam 10mg	14	14
6/29/18	6/29/18	diazepam 10mg	14	14
7/2/18	7/2/18	carisoprodol 250mg	20	20
7/13/18	7/19/18	alprazolam 2mg	33	11
7/13/18	7/18/18	alprazolam 2mg	6	2
7/13/18	7/16/18	alprazolam 2mg	6	2
7/13/18	7/16/18	gabapentin 300mg	45	15
7/19/18	7/19/18	eszopiclone 3 mg	15	15
7/27/18	7/27/18	alprazolam 2mg	45	15
7/27/18	7/27/18	zolpidem 10 mg	15	15
8/18/18	8/18/18	temazepam 30mg	7	7
8/10/18	8/13/18	alprazolam 2mg	60	20
8/10/18	8/13/18	zolpidem 10mg	30	30
8/10/18	8/13/18	gabapentin 300mg	90	30

b. Regarding Dr. Bajwa's treatment of Patient B, a then 22-year-old male, for complaints of anxiety from approximately January 2017 until his death due to fentanyl, morphine, and alprazolam intoxication on January 21, 2018:

i. Absent any assessment or documentation of symptoms or a substance use history and risk assessment, Dr. Bajwa prescribed Patient B alprazolam 1mg #90 (30-day supply) at his second office visit on February 4, 2017 visit, based on only the patient's report of "moderate" anxiety and his claim that he had taken alprazolam in the past. Only four days later, on February 8, 2017, Dr. Bajwa

authorized a telephone prescription for alprazolam 2mg TID #45 (15-day supply), a substantial dosage increase, without documenting any therapeutic purpose for doing so in the medical record.

ii. Also at his February 4, 2017 visit, Patient B complained of "muscle spasms, esp. lower back." Although Patient B disclosed his previous back surgery, Dr. Bajwa failed to obtain or document a detailed history related to such surgery, including prior treatments and therapies, before prescribing carisoprodol 350mg #30 (30-day supply).

iii. During a February 24, 2017 visit, Dr. Bajwa prescribed hydrocodone/acetaminophen (C-II) 10/325mg #30 (15-day supply) at Patient B's specific request due to an "exacerbation of back pain," without conducting an examination, ordering diagnostic testing, obtaining prior treatment records, or referring the patient for an appropriate work-up and further treatment.

iv. On March 27, 2017 and November 17, 2017, Dr. Bajwa respectively prescribed Patient B oxycodone/acetaminophen (C-II) 10/325mg #60, a 30-day supply, and oxycodone/acetaminophen 10/325mg #14, a 7-day supply, at Patient B's specific request, while failing to satisfy provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to do the following:

- Document having considered nonpharmacologic and non-opioid treatment for Patient B's complaints of pain, as required by 18 VAC 85-21-30(A).
- Perform a history and physical examination appropriate to the complaint, query the patient's PMP report, and conduct an assessment of the patient's history and risk of substance misuse prior to initiating treatment with an opioid, as required by 18 VAC 85-21-30(B).
- Document the extenuating circumstances justifying more than a seven-day supply, as required by 18 VAC 85-21-40(A)(1).
- Prescribe Naloxone when co-prescribing opioids and benzodiazepines or carisoprodol, as required by 18 VAC 85-21-40(B)(3).
- Document the extenuating circumstances justifying co-prescribing alprazolam with opioids and a tapering plan to achieve the lowest possible effective medication doses, as required

by 18 VAC 85-21-40(C).

- Document a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, and a treatment plan, as required by 18 VAC 85-21-50.

v. Dr. Bajwa failed to monitor and manage Patient B's use of the controlled substances he was prescribing. Specifically:

- Dr. Bajwa continued to prescribe opioids, several different benzodiazepines, and carisoprodol to Patient B without taking responsive action even though his check of the patient's October 18, 2017 PMP report revealed that Patient B received Suboxone on October 4, 2017.

- Although Dr. Bajwa admitted in his statement to the Board that he learned from the patient's mother that Patient B had a significant substance abuse and addiction history, including approximately two-years of intravenous heroin addiction and daily use, as well as opioid and benzodiazepine addiction and misuse, Dr. Bajwa failed to obtain or document a comprehensive mental health and substance misuse history, and did not take any steps to obtain the patient's prior treatment records or coordinate with the patient's other treating providers.

- Even after learning of Patient B's addiction and drug misuse history, Dr. Bajwa continued to prescribe controlled substances to the patient without monitoring or managing the elevated risk as follows:

  - Dr. Bajwa continued to prescribe Patient B alprazolam 2mg #90 and carisoprodol 350mg #90 approximately monthly from October 2017 through Patient B's death in January 2018 without conducting a single urine drug screen (UDS) or pill count.

  - Although Dr. Bajwa claimed in his statement to the Board that he checked Patient B's PMP report "with every visit," his PMP Access Audit records show that Dr. Bajwa prescribed controlled substances at office visits without checking the patient's PMP report on February 4, 2017; March 22, 2017; March 27, 2017; April 13, 2017; August 14, 2017; and September 9, 2017; and authorized telephonic prescriptions without checking the patient's PMP report on February 8, 2017; June 9, 2017; and January 15, 2018, approximately a week before Patient B's fatal overdose.

  - On November 7, 2017, Dr. Bajwa added lorazepam 1mg #14 (7-day supply) to Patient B's medication regimen for the first time absent any documentation in the medical records supporting a therapeutic purpose for the medication.

vi. Patient B voluntarily entered the Farley Center on January 6, 2018, for drug detox and substance abuse treatment. On January 15, 2018, although he had not seen Patient B in a month,

Dr. Bajwa authorized telephonic prescriptions for alprazolam 2mg #90 and carisoprodol 350mg #90. Patient B was administratively discharged from drug treatment on January 17, 2018, after he was found with the drugs Dr. Bajwa prescribed. Patient B died on January 21, 2018, as a result of fentanyl, morphine, and alprazolam intoxication.

c. Regarding Patient C, a then 29-year-old male, to whom Dr. Bajwa prescribed controlled substances from approximately January through August 2018:

i. At Patient C's first visit on January 30, 2018, Dr. Bajwa prescribed oxycodone/acetaminophen 7.5/325mg #14 (7-day supply) in response to Patient C's specific request and on May 25, 2018, again prescribed that medication for vague complaints of "moderate" back pain; prescribed oxycodone 15mg #60 (20-day supply) on June 4, 2018, when Patient C presented after a hip fracture and surgical repair requesting pain medication; prescribed oxycodone 15mg #30 (10-day supply) on August 13, 2018, for further complaints of pain related to the patient's May 2018 hip fracture; and co-prescribed alprazolam, while failing to satisfy provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to do the following:

- Consider or document having considered nonpharmacologic and non-opioid treatment for Patient C's complaints of pain prior to treatment with an opioid, as required by 18 VAC 85-21-30(A).
- Perform a history and physical examination appropriate to the complaint, query the patient's PMP report, and conduct an assessment of the patient's history and risk of substance misuse prior to initiating treatment with an opioid, as required by 18 VAC 85-21-30(B).
- Document the extenuating circumstances justifying prescribing greater than a seven-day supply of opioids on June 4, 2018 and August 13, 2018, as required by 18 VAC 85-21-40(A)(1).
- Document the extenuating circumstances justifying his August 13, 2018 opioid prescription outside of the immediate post-operative period (approximately two and a half months after the May 27, 2018 hip surgery), as required by 18 VAC 85-21-40(A)(2).
- Document in the medical record his reasons for exceeding 120 morphine milligram equivalent (MME)/day when he prescribed Patient C oxycodone 15mg #60 (20-day supply)

on June 4, 2018, in addition to the May 29, 2018, prescriptions for oxycodone 5mg #84 and morphine ER 15mg #40 that Patient C received from Fairfax Hospital on discharge after hip surgery, resulting in a total MME/day of 160.5, as required by 18 VAC 85-21-40(B)(2).

- Prescribe Naloxone when prescribing opioids in doses exceeding 120 MME/day and/or when co-prescribing opioids and benzodiazepines, as required by 18 VAC 85-21-40(B)(3).
- Document the extenuating circumstances justifying co-prescribing alprazolam with opioids and a tapering plan to achieve the lowest possible effective medication doses, as required by 18 VAC 85-21-40(C).
- Document a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, and a treatment plan, as required by 18 VAC 85-21-50.

ii. Based on Patient C's complaint of Attention Deficit Hyperactivity Disorder (ADHD) and request for medication "refills" at his first office visit on January 30, 2018, Dr. Bajwa had Patient C complete half of the 18-question Adult ADHD-Rating-Scale-IV, a self-assessment tool used as one part of a comprehensive ADHD work-up. Had Dr. Bajwa checked the patient's PMP report, he would have seen that Patient C was not in need of "refills," in that Patient C had not been prescribed Adderall or any other stimulant in the prior two years. Nonetheless, without conducting a comprehensive work-up or documenting any assessment as to whether Patient C's symptoms were clinically consistent with a diagnosis of ADHD, Dr. Bajwa prescribed Patient C Adderall (C-II) 15mg #60 (30-day supply).

iii. Dr. Bajwa failed to monitor and manage Patient C's use of controlled substances, and continued to prescribe multiple controlled substances to Patient C when he knew or should have known that Patient C was exhibiting signs and symptoms of addiction or medication overuse, abuse, or misuse. Specifically:

- At his March 14, 2018 visit, Patient C complained that his Adderall 15mg prescription (#30 filled March 5, 2018) was "not strong enough & wants dose adjusted." Patient C also reported that he was using the previously prescribed alprazolam 1mg more frequently than as prescribed. Notwithstanding this overuse of prescribed medication and medication seeking behavior, and absent a PMP report check, Dr. Bajwa prescribed alprazolam 1mg TID #90, and Adderall 20mg BID #60, thus significantly increasing the daily dosage of

both medications without a valid therapeutic reason for doing so.

- At an April 19, 2018 office visit, Dr. Bajwa provided new prescriptions for Adderall 20mg #60 and alprazolam 1mg #90 (both filled April 19, 2018) when Patient C stated that "he lost his meds & needs early refill."

- At his May 21, 2018 visit, Patient C complained that alprazolam "1mg not strong enough & needs dose adjusted." Absent any documentation supporting a therapeutic purpose or need for increasing the dose above the manufacturer recommended dose of 4mg/day, Dr. Bajwa doubled the strength and prescribed alprazolam 2mg #90 (30-day supply). Four days later, on May 25, 2018, Patient C stated his alprazolam was "taken from him & needs refill," and Dr. Bajwa prescribed alprazolam 2mg #90 (30-day supply).

- Dr. Bajwa admitted in his statement to the Board that he recommended Patient C see a psychiatrist. However, when Patient C declined, and stated that he wanted only Dr. Bajwa to "treat his psychiatric conditions," Dr. Bajwa took no action and continued to prescribe benzodiazepines and amphetamines.

- Although Dr. Bajwa noted that Patient C was treated at Fairfax Hospital after being hit by a car, he failed to review or request those medical records or speak with any of those providers. Had he done so, he would have learned the following:

  - Patient C suffered a fracture to his right acetabulum during a fight outside a bar, rather than a car accident, which necessitated surgical repair.

  - During his admission, he admitted to recreational drug use including marijuana.

  - While hospitalized, he was found taking controlled substances from home, not taking the pain medication given to him in the hospital and instead, "saving it for later."

  - The patient's wife and friend were noted to have slurred speech and unsteady gaits while visiting Patient C.

3. Dr. Bajwa violated Virginia Code §§ 54.1-2915(A)(3), (12), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A) and 18 VAC 85-20-26(C) of the Board's General Regulations in his care and treatment of Patients D-H between July 2015 and May 2017. Specifically:

a. Regarding Patient D, a then 31-year-old female and spouse of Patient E, who presented to Dr. Bajwa on May 19, 2014, with a chief complaint of neck pain and muscle spasms recently exacerbated:

i. Although Dr. Bajwa told Patient D that he would not prescribe her any

narcotics, he nonetheless prescribed tramadol 50mg #150 at the patient's first visit, absent a diagnosis and without reviewing or attempting to obtain prior medical records or imaging reports, developing a treatment plan, or ordering a workup for the patient's complaint of neck pain.

ii. In spite of noting on multiple occasions that Patient D was obtaining Norco (hydrocodone/acetaminophen) from her gynecologist for endometriosis, Dr. Bajwa began prescribing Patient D oxycodone 10mg #60 (30-day supply) on July 15, 2015 for complaints of pelvic pain. Dr. Bajwa failed to document whether he checked the patient's PMP report and did not document any psychiatric or substance use history, nor did Dr. Bajwa communicate with Patient D's gynecologist in order to coordinate their opioid prescribing.

iii. Dr. Bajwa continued to prescribe tramadol and oxycodone to Patient D regularly for complaints of neck pain even though a September 7, 2014, MRI showed only mild degenerative cervical spondylosis. Moreover, Dr. Bajwa failed to initiate any treatment other than opioids for the patient's neck pain (e.g., neuromodulators, physical therapy), and failed to refer the patient for an appropriate evaluation and treatment of her neck pain.

iv. Patient D presented to Dr. Bajwa's office on December 24, 2015, 24 hours after undergoing a laparoscopic total hysterectomy and right salpingectomy requiring an overnight hospital stay. Patient D complained of post-operative pain and told Dr. Bajwa that hydromorphone had worked well for her in the past. Without checking the patient's PMP report or verifying with the surgeon and/or hospital what medications the patient had received in the hospital and were prescribed/provided to her at discharge, Dr. Bajwa prescribed hydromorphone 4mg #30 (15-day supply), and oxycodone 30mg #30 (15-day supply).

v. Dr. Bajwa continued prescribing opioids to Patient D through April 2017 for complaints of neck and pelvic pain, routinely prescribing such medications prior to the time the

prescriptions should have needed to be refilled had the medications been taken as prescribed, and without addressing Patient D's overuse of the opioids he was prescribing, as follows:

Date Written	Medication Dose/ Quantity	Days Supply Per PMP Report/MME	Date Previous Rx	Days Supply for Prior Rx Per PMP Report
8/5/15	Oxycodone 10mg #30	30/15	7/15/15	30 day supply
8/5/15	Tramadol 50mg #120	30/20	7/15/15	30 day supply
8/31/15	Oxycodone 10mg #60	30/30	8/5/15	30 day supply
8/31/15	Tramadol 50mg #130	21/31	8/5/15	30 day supply
9/23/15	Oxycodone 10mg #60	30/30	8/31/15	30 day supply
1/4/16	Oxycodone 15mg #60	30/45	12/24/15	15 day supply
1/20/16	Oxycodone 30mg #90	30/135	1/4/16	30 day supply
1/20/16	Tramadol 50mg #90	30/15	1/4/16	30 day supply
4/22/16	Oxycodone 30mg #90	30/135	3/31/16	30 day supply
6/29/16	Oxycodone 30mg #90	30/135	6/6/16	30 day supply
6/29/16	Tramadol 50mg #90	30/15	6/6/16	30 day supply
8/15/16	Tramadol 50mg #90	30/15	7/22/16	30 day supply
9/7/16	Tramadol 50mg #30	30/5	8/15/16	30 day supply
3/13/17	Oxycodone 30mg #150	25/270	2/24/17	30 day supply
3/31/17	Oxycodone 30mg #180	30/270	3/13/17	25 day supply
4/24/17	Oxycodone 30mg #180	30/270	3/31/17	30 day supply

vi. Dr. Bajwa began prescribing Patient D clonazepam 0.5mg #60 (30-day supply) on January 20, 2016, absent any documentation in the medical record supporting a therapeutic need, and without documenting any psychiatric or substance use history. On February 24, 2017, Dr. Bajwa significantly increased the daily dosage of clonazepam prescribed to 2mg #60 (30-day supply) absent any documentation supporting a therapeutic need for doing so.

b. Regarding Patient E, a then 29-year-old male, and spouse of Patient D:

i. Patient E presented to Dr. Bajwa on June 5, 2014, to establish care, with a chief complaint of "hip pain" for which the patient was prescribed OxyContin, oxycodone, and tramadol by a physician at an orthopedic and spine care practice in the recent past. Although Dr. Bajwa told Patient E that he "would not write any narcotics for him," Dr. Bajwa nonetheless prescribed Patient E tramadol 50mg 1-2 tabs TID prn #150 on that date without performing a physical exam, formulating a diagnosis,

obtaining a detailed history including substance use, checking the patient's PMP report, conducting a UDS, developing a treatment plan, or coordinating his care with other treating providers.

ii. In spite of telling Patient E he would not prescribe narcotics, on July 1, 2015, Dr. Bajwa prescribed oxycodone/acetaminophen 10/325mg #30 (30-day supply) for a diagnosis of hip pain without having checked the patient's PMP report, verifying with Patient E's other treating providers that they were not also concurrently prescribing controlled substances, conducting a UDS, or documenting a treatment plan.

iii. Dr. Bajwa continued prescribing Patient E opioids through May 2017 when he knew or should have known that the patient was exhibiting signs of addiction and misuse. Specifically:

- Dr. Bajwa steadily increased the strength and/or quantity of oxycodone he prescribed Patient E based on the patient's specific requests on July 24, 2015; August 19, 2015; October 10, 2015; November 23, 2015; December 17, 2015; February 2, 2016; June 21, 2016; and August 5, 2016.

- Dr. Bajwa prescribed Patient E fentanyl 100mcg #15 on September 3, 2016 because the patient "has friend on fentanyl & wants to see if this will be more effective." Moreover, Dr. Bajwa prescribed hydromorphone 8mg #30 to Patient E on January 18, 2017 when the patient complained that the cold weather made his pain worse, and because "He tried Dilaudid in past and requests one/day as needed."

- Dr. Bajwa failed to take any steps to monitor Patient E's drug use by performing UDS' or regularly checking, or documenting having checked, the patient's PMP report.

- Dr. Bajwa prescribed opioids prior to the time the prescriptions should have needed to be refilled if the medications were taken as prescribed and failed to take any appropriate responsive action in spite of the patient's demonstrated overuse of opioids, as set forth below:

Date Written	Medication Dose/ Quantity	Days Supply Per PMP Report/MME	Date of Previous Rx	Days Supply for Prior Rx Per PMP Report
7/24/15	oxycodone 10mg #60	30/30	7/1/15	30 day supply
10/29/15	oxycodone 15mg #60	30/45	10/5/15	30 day supply
11/23/15	tramadol 50mg #120	30/20	10/29/15	30 day supply
11/23/15	oxycodone 30mg #60	30/90	10/29/15	30 day supply
12/17/15	oxycodone 30mg #90	30/135	11/23/15	30 day supply

12/17/15	tramadol 50mg #90	30/15	11/23/15	30 day supply
1/11/16	oxycodone 30mg #90	30/135	12/17/15	30 day supply
1/11/16	tramadol 50mg #90	30/15	12/17/15	30 day supply
2/5/16	oxycodone 30mg #90	30/135	1/11/16	30 day supply
2/5/16	tramadol 50mg #90	30/15	1/11/16	30 day supply
2/29/16	tramadol 50mg #60	30/10	2/5/16	30 day supply
2/29/16	oxycodone 30mg #120	30/180	2/5/16	30 day supply
5/6/16	tramadol 50mg #60	30/10	4/15/16	30 day supply
5/6/16	oxycodone 30mg #120	30/180	4/15/16	30 day supply
5/31/16	tramadol 50mg #60	30/10	5/6/16	30 day supply
6/21/16	oxycodone 30mg #150	25/270	5/31/16	30 day supply
8/5/16	oxycodone 30mg #180	30/270	7/15/16	30 day supply
8/26/16	oxycodone 30mg #180	30/270	8/5/16	30 day supply
9/19/16	oxycodone 30mg #180	30/270	8/26/16	30 day supply
10/10/16	oxycodone 30mg #180	30/270	9/19/16	30 day supply
2/9/17	hydromorphone 8mg #30	30/32	1/18/17	30 day supply
2/9/17	oxycodone 30mg #150	25/270	1/18/17	25 day supply
3/2/17	oxycodone 30mg #180	30270	2/9/17	25 day supply
3/21/17	oxycodone 30mg #180	30/270	3/2/17	30 day supply
4/12/17	oxycodone 30mg #180	30/270	3/21/17	30 day supply
5/6/17	oxycodone 30mg #180	30/270	4/12/17	30 day supply

c. Regarding Patient F, a then 48-year-old female:

i. Dr. Bajwa began prescribing alprazolam 1mg #90 (30-day supply) on July 6, 2015 for a diagnosis of anxiety, absent any assessment or description of the patient's symptoms or substance use history.

ii. At Patient F's next visit on August 8, 2015, Dr. Bajwa began prescribing carisoprodol 350mg #60 (30-day supply) for a diagnosis of muscle spasms, absent any documented physical examination, description of symptoms, or associated information relating to the spasms.

iii. Dr. Bajwa began prescribing opioids regularly to Patient F on December 8, 2015 for complaints of back pain at the request of another physician. Although a November 6, 2012 MRI report included in Dr. Bajwa's records showed only mild encroachment of the left neural foramen at L4-5, Dr. Bajwa nonetheless continued regularly prescribing hydromorphone 4mg #120 (30-day supply) and methadone 10mg #120 (two tabs BID, 30-day supply) (total 384 MME/day) through October 2016.

iv. Dr. Bajwa failed to monitor and manage Patient F's use of controlled substances, in that he did not conduct any UDS' or pill counts during the treatment period. Moreover, Dr. Bajwa failed to respond to the patient's overuse of the controlled substances he was prescribing, and regularly provided prescriptions prior to the time the medications should have needed to be refilled had Patient F taken them as prescribed, as set forth below:

Date Written	Medication Dose/Quantity	Days Supply Per PMP Report/MME	Date of Previous Rx	Days Supply for Prior Rx Per PMP Report
2/24/16	alprazolam 1mg #90	30	2/1/16	30
2/24/16	carisoprodol 350mg #90	30	2/1/16	30
2/24/16	methadone 10mg #120	30/320	2/1/16	30
2/25/16	hydromorphone 4mg #120	30/64	2/1/16	30
3/22/16	hydromorphone 4mg #120	30/64	2/25/16	30
3/22/16	methadone 10mg #120	30/320	2/24/16	30
6/6/16	alprazolam 1mg #90	30	5/16/16	30
6/6/16	carisoprodol 350mg #90	30	5/16/16	30
6/6/16	hydromorphone 4mg #120	30/64	5/16/16	30
6/6/16	methadone 10mg #120	30/320	5/16/16	30
6/27/16	alprazolam 1mg #90	30	6/6/16	30
6/27/16	carisoprodol 350mg #90	30	6/6/16	30
6/27/16	hydromorphone 4mg #120	30/64	6/6/16	30
6/27/16	methadone 10mg #120	30/320	6/6/16	30
7/8/16	methadone 10mg #120	30/320	6/27/16	30
7/18/16	hydromorphone 4mg #120	30/64	6/27/16	30
8/12/16	hydromorphone 4mg #120	30/64	7/18/16	30
9/6/16	hydromorphone 4mg #120	30/64	8/12/16	30
9/6/16	methadone 10mg #120	30/320	8/12/16	30
10/27/16	alprazolam 1mg #90	30	10/4/16	30
10/27/16	hydromorphone 4mg #120	30/64	10/4/16	30
10/27/16	methadone 10mg #120	30/320	10/4/16	30

d. Regarding Patient G, a then 48-year-old female:

i. Dr. Bajwa prescribed Patient G oxycodone/acetaminophen 5/325mg #30 (15-day supply) at her first visit on February 9, 2016, for her complaint of shoulder pain without performing or documenting an appropriate physical examination, obtaining a detailed medical and substance use history, or obtaining or reviewing prior medical records. Three days later, Dr. Bajwa

increased the oxycodone/acetaminophen to 10/325mg BID #30 at the patient's request absent documentation of any therapeutic support for that change in the medical record.

ii. Dr. Bajwa continued prescribing Patient G oxycodone through 2017 and took no action in spite of the patient's signs of addiction and misuse. Specifically:

- When Patient G reported at her March 8, 2016 visit that she had been taking the oxycodone/acetaminophen more frequently than prescribed, Dr. Bajwa increased the prescription to TID, and then increased it to QID at the patient's request during her next visit on March 21, 2016, without any documentation supporting a therapeutic need for the increased dose at either visit.

- In spite of a June 2016 MRI and orthopedic consult diagnosing shoulder tendinosis, and recommending a steroid injection, physical therapy, and anti-inflammatories, Dr. Bajwa continued prescribing oxycodone/acetaminophen through April 2017, did not prescribe anti-inflammatory medication, and did not require Patient G to follow through with physical therapy and steroid injections as conditions of treatment. In addition to prescribing oxycodone/acetaminophen in spite of the orthopedist's recommendation, Dr. Bajwa added hydromorphone 4mg #60 (15-day supply) to Patient G's drug regimen on March 22, 2017 due to "increased pain at night."

- Dr. Bajwa failed to take any action in spite of the patient's overuse of oxycodone/acetaminophen, and regularly prescribed opioids prior to the time the prescriptions should have needed to be refilled if taken as prescribed, as follows:

Date Written	Medication/Quantity	Days Supply per PMP Report/MME	Date Previous Rx	Days Supply for Prior Rx Per PMP Report
3/8/16	oxycodone/acetaminophen 10/325mg #63	21/45	2/25/16	15
3/21/16	oxycodone/acetaminophen 10/325mg #120	30/60	3/8/16	21
5/2/16	oxycodone/acetaminophen 10/325mg #90	30/45	4/20/16	27
5/18/16	oxycodone/acetaminophen 10/325mg #120	30/60	5/2/16	30
7/26/16	oxycodone/acetaminophen 10/325mg #80	20/60	7/11/16	30
9/14/16	oxycodone/acetaminophen 10/325mg #30	7/64.5	9/7/16	27
9/19/16	oxycodone/acetaminophen 10/325mg #90	23/58.5	9/14/16	7
1/4/17	oxycodone/acetaminophen 7.5/325mg #120	30/45	12/30/16	30
1/25/17	oxycodone/acetaminophen 10/325mg	30/60	1/4/17	30

	#120			
2/7/17	oxycodone 10mg #120	30 /60	1/30/17	30

e. Regarding Patient H, a then 43-year-old male:

i. Dr. Bajwa assumed the care, treatment, and regular controlled substance prescribing for Patient H from his prior physician, a psychiatrist and pain management specialist, in approximately November 2015. Dr. Bajwa failed to perform or document an appropriate physical examination; document appropriate information regarding the patient's complaints of abdominal pain, including a diagnosis; document a substance use history; or develop or document a comprehensive treatment plan prior to prescribing hydromorphone 4mg #60 (20-day supply), tramadol 50mg #120 (30-day supply), and diazepam 10mg #90 (30-day supply) at the first visit.

ii. Although Dr. Bajwa's records from the prior physician indicate that she was concerned the patient possibly had track/injection marks on his arms, Dr. Bajwa failed to follow up on this information by, for example, monitoring Patient H for the appearance of track marks or using UDS' to ensure the patient's compliance with his medication regimen. In spite of these concerns, Dr. Bajwa prescribed hydromorphone and diazepam on December 7, 2015, December 19, 2015, and May 9, 2016, dates when those medications should not have needed to be refilled had Patient H taken them as prescribed, and failed to take any action in response to the patient's overuse of hydromorphone and diazepam.

4. Dr. Bajwa violated Virginia Code §§ 54.1-2915(A)(3), (12), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A), 18 VAC 85-20-26(C) of the Board's General Regulations, and 18 VAC 85-21-60 to -120 of the Board's Prescribing Regulations *[effective for conduct on or after March 15, 2017]*, from approximately July 2015 through January 2018, with regard to his care and treatment of, and continuous prescribing of controlled substances to, Patients I and J, a married couple. Specifically:

a. Regarding Patient I, a then 35-year-old female:

i. Dr. Bajwa began prescribing diazepam 10mg #60 and zolpidem 10mg #30

to Patient I in July 2015 for diagnoses of insomnia and migraines without conducting or documenting a comprehensive physical examination, description of symptoms, or a substance use history and risk assessment, and notwithstanding the fact that diazepam is not indicated for the treatment of migraines.

ii. Dr. Bajwa failed to document any symptoms, findings, or rationale supporting his prescribing of alprazolam to Patient I, given that benzodiazepines and other sedative-hypnotics are generally not recommended for the treatment of migraines, nor did Dr. Bajwa confirm a therapeutic purpose for such prescribing through a neurological workup.

iii. Dr. Bajwa prescribed Patient I morphine sulfate ER 60mg BID #60 on August 14, 2015, at the request of another physician "for August" due to an "insurance change." Although Dr. Bajwa's diagnoses supporting this prescription were insomnia, migraines, and elevated cholesterol, he failed to document any explanation for prescribing medication not recommended to treat any of those documented diagnoses. Moreover, Dr. Bajwa failed to document any prior history related to such opioid prescribing, a physical examination, a description of the pain he was treating, a pain rating, or any other information in support of his prescribing.

iv. On February 17, 2016, Dr. Bajwa became Patient I's pain management provider, and began regularly prescribing her morphine sulfate ER 60mg #60 and hydromorphone 8mg #120 for the diagnoses of insomnia, migraines, and elevated cholesterol with insufficient medical support for such opioid prescribing documented in the patient's record. Specifically, although Patient I's chart included some prior records of her fourteen-year treatment with opioids for head, neck, and chronic "diffuse" pain by various physicians and a pain management clinic, among others, none of the records contained a definitive diagnosis supporting opioid therapy or documented a detailed substance use history.

v. Although Patient I's pain management clinic records include a May 22, 2015, UDS positive for a metabolite of heroin, Dr. Bajwa failed to monitor and manage Patient I's use of

controlled substances, in that he failed to check the patient's PMP report until May of 2017 and did not conduct any pill counts, UDS', or take any other appropriate measures to determine whether Patient I was taking the medications as prescribed and was otherwise compliant during the time he prescribed controlled substances.

vi. After Patient I's five-month absence from Dr. Bajwa's practice, he resumed prescribing morphine sulfate ER 60mg #60 and hydromorphone 8mg #120 to the patient on July 1, 2016, after documenting merely "↑chol, insomnia, migraines all 3 stable w/ meds" without any documentation regarding the patient's absence or the performance or documentation of a physical exam or UDS.

vii. Based on Patient I's complaint of "ADHD symptoms" and request for medication "refills" at a July 3, 2017 office visit, Dr. Bajwa had Patient I complete half of the Adult ADHD-Rating-Scale-IV. Without conducting a comprehensive physical or mental examination or documenting any assessment as to whether Patient I's symptoms were clinically consistent with a diagnosis of ADHD, Dr. Bajwa prescribed her Adderall 20mg #30 (30-day supply).

b. Regarding Patient J, a then 34-year-old male, who Dr. Bajwa treated for complaints of anxiety and insomnia:

i. Dr. Bajwa began prescribing diazepam 10mg BID #60 and Sonata (C-IV) 10mg QD #30 to Patient J in June 2015 for diagnoses of anxiety and insomnia without conducting or documenting a comprehensive physical examination, description of symptoms, a substance use history and risk assessment, or findings supporting a therapeutic purpose.

ii. Dr. Bajwa prescribed Patient J morphine sulfate ER 60mg BID #60 and hydromorphone 4mg TID #90 on August 14, 2015, at the request of another physician "for August" due to an "insurance change." Dr. Bajwa's diagnoses supporting the prescriptions were insomnia, hypertension, and GERD, conditions which did not warrant such opioid prescribing. Dr. Bajwa failed to

document any prior history related to such prescribing, a physical examination, a description of the pain, a pain rating, or any other information in support of his prescribing opioids for the documented diagnoses.

iii. Dr. Bajwa began prescribing Patient J carisoprodol 350mg #60 on November 16, 2015 based on the same diagnoses of hypertension, insomnia, and GERD, absent any documentation indicating a therapeutic or medicinal need for a muscle relaxant to treat the documented diagnoses.

iv. On December 12, 2016, Dr. Bajwa assumed Patient J's pain management and began regularly prescribing him morphine sulfate ER 60mg and hydromorphone 8mg for diagnoses of hypertension, insomnia, and GERD without establishing sufficient medical support for such opioid prescribing in the patient's record. Specifically, while Patient J's chart included some prior records from Dr. Greene, those records contain documentation of only Patient J's self-report of long-term back pain, but do not contain any documentation of a workup for back pain, imaging, referrals for further evaluation, or a definitive diagnosis and treatment.

v. In spite of a May 2, 2016 progress note from another physician discussing a UDS positive for methadone, a medication not prescribed to Patient J, Dr. Bajwa failed to monitor and manage Patient J's use of controlled substances, in that he failed to check the patient's PMP report until May of 2017, did not conduct any pill counts or UDS', or take any other appropriate measures to determine whether Patient J was taking the medications as prescribed and was otherwise compliant during the time he prescribed controlled substances.

vi. In spite of the fact that Patient J had not had a work up for his back pain, Dr. Bajwa continued prescribing opioids to Patient J through January 2018 without conducting or referring Patient J for a work up to determine a diagnosis and appropriate treatment.

c. Dr. Bajwa prescribed Patients I and J opioids regularly from March 2017 through January 2018 while failing to satisfy the provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to:

- Document a medical history and physical examination, to include a mental status examination, including:
  - The nature and intensity of the pain;
  - Current and past treatments for pain;
  - Underlying or coexisting diseases or conditions;
  - The effect of the pain on physical and psychological function, quality of life, and activities of daily living;
  - Psychiatric, addiction, and substance misuse history of the patient and any family history of addiction or substance misuse;
  - A urine drug screen or serum medication level;
  - A query of the PMP as set forth in § 54.1-2522.1 of the Code of Virginia;
  - An assessment of the patient's history and risk of substance misuse; and
  - A request for prior applicable records;

  as required by 18 VAC 85-21-60(A).

- Discuss or document having discussed with Patients I and J the risks and benefits of opioid therapy and the patients' responsibilities during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs, and an exit strategy for the discontinuation of opioids in the event they are not effective, as required by 18 VAC 85-21-60(B).

- Give consideration to nonpharmacologic and non-opioid treatment for pain prior to treatment with opioids, as required by 18 VAC 85-21-70(A).

- Calculate the MME/day and, further, failed to document in the medical records the reasonable justification for prescribing Patients I and J opioids in quantities consistently resulting in a MME/day in excess of 120 for both, or refer the patients to or consult with a pain management specialist, as required by 18 VAC 85-21-70(B)(2).

- Prescribe Naloxone to Patients I and J, whose risk factors included the prescription of opioid doses in excess of 120 MME/day and concomitant benzodiazepine prescribing, as required by 18 VAC 85-21-70(B)(3).

- Document the rationale to continue opioid therapy every three months, as required by 18 VAC 85-21-70(B)(4).

- Document the extenuating circumstances justifying his co-prescribing of morphine sulfate ER, hydromorphone, alprazolam, and carisoprodol to Patients I and J and failed to

document in their medical records tapering plans to achieve the lowest possible effective doses of these medications, as required by 18 VAC 85-21-70(D).

- Regularly evaluate the patients for opioid use disorder, or document having done so, as required by 18 VAC 85-21-70(E).

- Document treatment plans for Patients I and J that state measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities; include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary; and document the presence or absence of any indicators of medication misuse or diversion and take appropriate responsive action thereto, as required by 18 VAC 85-21-80(A) – (C).

- Document in the medical record any discussion of informed consent with Patients I and J, nor did Dr. Bajwa obtain a signed written treatment agreement with either patient that addressed the parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care, and permission for Dr. Bajwa to query the patients' PMP reports, obtain UDS', serum or saliva medication levels, and consult with other prescribers or dispensing pharmacists, as required by 18 VAC 85-21-90(A)-(C).

- Perform the following:
  - review the course of pain treatment and the patient's state of health at least every three months;
  - document and assess the continued benefit from such prescribing;
  - conduct and review a urine or serum drug screen at the initiation of chronic pain management and thereafter randomly at the discretion of the practitioner, but at least once a year; and
  - evaluate and document that he regularly evaluated the patients for opioid use disorder, as required by 18 VAC 85-21-100(A)-(B), (D)-(E).

- Keep current, accurate, and complete records in an accessible manner readily available for review including the medical history and physical examination; diagnostic, therapeutic, and laboratory results; evaluations; treatment goals; treatments; patient instructions; and periodic reviews, as required by 18 VAC 85-21-120.

d. Dr. Bajwa failed to monitor and manage the care of Patients I and J, in that he repeatedly prescribed highly abusable controlled substances prior to the time the prescriptions should have needed to be refilled had the medications been taken as prescribed, and failed to take any responsive action to the patients' obvious overuse of the drugs he was prescribing, as follows:

Patient	Date Written	Medication/Quantity	Days Supply per PMP	Date Previous	Days Supply for Prior Rx Per

J	3/1/17	hydromorphone 8mg #120	30/128	2/20/17	30
J	3/30/17	alprazolam 2mg #90	30	3/4/17	30
J	4/24/17	morphine sulfate ER 60mg #60	30/120	4/1/17	30
J	4/24/17	hydromorphone 8mg #54	14/124.8	3/30/17	30
J	5/22/17	hydromorphone 8mg #60	15/128	5/12/17	15
J	5/30/17	hydromorphone 8mg #60	15/128	5/22/17	17
J	7/11/17	morphine sulfate ER 60mg #30	30/60	6/19/17	30
J	7/11/17	hydromorphone 8mg #60	30/96	6/19/17	30
J	8/18/17	alprazolam 2mg #66	22	8/9/17	30
J	8/18/17	morphine sulfate ER 15mg #30	30/15	8/12/17	30
J	8/18/17	hydromorphone 8mg #60	30/64	8/9/17	30
J	8/30/17	carisoprodol 350mg #60	30	8/9/17	30
J	9/12/17	hydromorphone 4mg #90	30/48	8/18/17	30
J	10/6/17	hydromorphone 4mg #75	30/10	9/12/17	30
J	10/16/17	alprazolam 2mg #90	30	9/20/17	30
J	10/25/17	hydromorphone 8mg #65	16/128	10/6/07	30
I	5/30/17	hydromorphone 8mg #120	30/128	5/19/17	30
I	7/11/17	morphine sulfate ER 60mg #30	30/60	6/19/17	30
I	7/25/17	amphetamine 20mg #30	30	7/3/17	30
I	8/18/17	hydromorphone 4mg #90	30/48	8/4/17	30
I	12/11/17	amphetamine 20mg #30	30	11/17/17	30

5. Dr. Bajwa violated Virginia Code §§ 54.1-2915(A)(3), (12), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A); 18 VAC 85-20-26(C) of the Board's General Regulations; and 18 VAC 85-21-30 to -120 of the Board's Prescribing Regulations (*effective for conduct on or after March 15, 2017*), from approximately May through October 2018 with regard to his care and treatment of Patients K-O, all of whom lived in the Winchester, Virginia area and travelled approximately 90 minutes each way to Dr. Bajwa's Fairfax office. For example:

a. Dr. Bajwa prescribed Patient K hydrocodone/acetaminophen 10/325mg #14 (7-day supply) on August 15, 2018 and October 2, 2018, and oxycodone 10mg (7-day supply) on September 11, 2018; Patient L oxycodone/acetaminophen 10/325mg #14 (7-day supply) on July 5, 2018, July 19, 2018, and August 8, 2018, and hydrocodone/acetaminophen 10/325mg #20 (10-day supply) on August 13, 2018; and Patient M oxycodone/acetaminophen 10/325mg #10 (5-day supply) on October 18, 2018, while failing to satisfy the provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to:

i. Document having considered nonpharmacologic and non-opioid treatment for the patients' complaints of pain, as required by 18 VAC 85-21-30(A).

ii. Prior to prescribing opioids, perform a history and physical examination appropriate to the complaint, query the patients' PMP reports, and conduct an assessment of each patient's history and risk of substance misuse, as required by 18 VAC 85-21-30(B).

iii. Document the extenuating circumstances justifying more than a seven-day supply when he prescribed Patient L hydrocodone 10mg #20 (10-day supply) on August 13, 2018, as required by 18 VAC 85-21-40(A)(1).

iv. Prescribe Naloxone while co-prescribing benzodiazepines with opioids to Patients K, L, and M, as required by 18 VAC 85-21-40(B)(3).

v. Document the extenuating circumstances justifying co-prescribing alprazolam with opioids to Patients K, L, and M, and also failed to document tapering plans for the patients to achieve the lowest possible effective medication doses, as required by 18 VAC 85-21-40(C).

vi. Document a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, and a treatment plan for Patients K, L, and M, as required by 18 VAC 85-21-50.

b. Dr. Bajwa provided chronic pain management from May through October 2018 to Patient N, prescribing hydrocodone/acetaminophen 10/325mg #14 (7-day supply) on May 29, 2018, June 18, 2018, July 17, 2018, September 28, 2018, and October 6, 2018; oxycodone 10mg #14 (7-day supply) on August 13, 2018; hydrocodone/acetaminophen 7.5/325mg #14 (7-day supply) on September 6, 2018; and tramadol 50mg #14 (7-day supply) on September 19, 2018, and October 15, 2018, while failing to satisfy provisions of the Board's Prescribing Regulations. Specifically, Dr. Bajwa failed to:

i. Document a medical history and physical examination, to include a mental

status examination and:

- The nature and intensity of the pain;
- Current and past treatments for pain;
- Underlying or coexisting diseases or conditions;
- The effect of the pain on physical and psychological function, quality of life, and activities of daily living;
- Psychiatric, addiction, and substance misuse history of the patient and any family history of addiction or substance misuse;
- A UDS or serum medication level;
- A query of the PMP as set forth in § 54.1-2522.1 of the Code of Virginia;
- An assessment of the patient's history and risk of substance misuse; and
- A request for prior applicable records;

as required by 18 VAC 85-21-60(A).

ii. Discuss with Patient N, or documenting having done so, the risks and benefits of opioid therapy and the responsibilities of Patient N during treatment to include securely storing the medication and properly disposing of any unwanted or unused medication, and an exit strategy for the discontinuation of opioids in the event they were not effective, as required by 18 VAC 85-21-60(B).

iii. Give consideration to nonpharmacologic and non-opioid treatment for pain prior to treatment with opioids, as required by 18 VAC 85-21-70(A).

iv. Prescribe Naloxone to Patient N as required for concomitant benzodiazepine use, and further, failed to document the rationale to continue opioid therapy every three months, as required by 18 VAC 85-21-70(B)(3), (4).

v. Document the extenuating circumstances justifying his co-prescribing of oxycodone and hydrocodone/acetaminophen with alprazolam and carisoprodol, nor did Dr. Bajwa document in the medical record a tapering plan to achieve the lowest possible effective doses of these medications, as required by 18 VAC 85-21-70(D).

vi. Regularly evaluate Patient N for opioid use disorder, or document having done so, as required by 18 VAC 85-21-70(E).

vii. Document a treatment plan for Patient N's chronic pain management, as required by 18 VAC 85-21-80(A).

viii. Document in the medical record any discussion of informed consent with Patient N, nor did Dr. Bajwa obtain a written treatment agreement signed by Patient N in the medical record that addresses the parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care, and permission for Dr. Bajwa to consult with other prescribers, as required by 18 VAC 85-21-90(A)-(C).

ix. Review the course of pain treatment and Patient N's state of health at least every three months; document the continued benefit from such prescribing; and check the patient's PMP report at least every three months after the initiation of treatment, as required by 18 VAC 85-21-100(A)-(C). In fact, although Dr. Bajwa began prescribing opioids to Patient N in May 2018, he did not check the patient's PMP report until October 6, 2018.

x. Keep current, accurate, and complete records in an accessible manner readily available for review including the medical history and physical examination and diagnostic, therapeutic, and laboratory results, as required by 18 VAC 85-21-120.

c. Based on self-reports of a history of ADHD with stimulant treatment from Patients K-O, Dr. Bajwa had each patient complete an Adult ADHD-Rating-Scale-IV. Without performing a comprehensive physical or mental examination or documenting any assessment as to whether the patients' symptoms were clinically consistent with a diagnosis of ADHD, Dr. Bajwa prescribed Patients K-O stimulants continuously from approximately April through October 2018.

d. Dr. Bajwa prescribed Patient O alprazolam 1mg #60 (30-day supply) and zolpidem 10mg #30 (30-day supply) at her first office visit on October 1, 2018, based solely on the patient's self-report of anxiety without conducting a comprehensive examination or documenting symptoms and

findings supporting the patient's complaints. Moreover, although Patient O reported a history of depression, Dr. Bajwa failed to take or otherwise verify a detailed mental health and substance use history. Had Dr. Bajwa done so, he would have learned that Patient O had a history of substance misuse/abuse, including use of cocaine, heroin, PCP, alcohol, opioids, and benzodiazepines she purchased off the streets, as well as bipolar disorder treated with Geodon and Elavil.

6. Dr. Bajwa violated Virginia Code §§ 54.1-2915(A)(3), (12), (13), (16), (17), and (18), 54.1-3303(A), and 54.1-3408(A) and 18 VAC 85-20-26(C) of the Board's General Regulations, with regard to his care and treatment of Patients P-T. For example:

a. Regarding Patient P, a 39-year-old female, who Dr. Bajwa treated from approximately February 2018 through October 2018 for anxiety and ADHD:

i. Dr. Bajwa prescribed Patient P alprazolam 0.5mg #30 (30-day supply) at her first office visit on February 22, 2018 based solely on the patient's self-report of anxiety without conducting a comprehensive examination, documenting symptoms or findings supporting the patient's complaints, or verifying Patient P's substance use and mental health history, through, for example, reviewing prior medical records. Had Dr. Bajwa done so, he would have learned that Patient P had a lengthy psychiatric history including diagnoses of bipolar disorder and borderline personality disorder; noncompliance with prescribed medications; substance misuse with cocaine, benzodiazepines, and amphetamines; and multiple psychiatric hospitalizations triggered by suicidal ideation occurring on December 13, 2016, March 10, 2017, March 31, 2017, and November 28, 2017.

ii. At the same February 22, 2018 visit, Dr. Bajwa prescribed Patient P Adderall 20mg #30 (30-day supply) based solely on the patient's self-report of an ADHD history, without conducting a comprehensive physical or mental examination or documenting any assessment as to whether the patient's symptoms were clinically consistent with a diagnosis of ADHD.

iii. Dr. Bajwa continued to prescribe multiple controlled substances to Patient P when he knew or should have known that she was exhibiting signs and symptoms of addiction or medication overuse/misuse, in that Dr. Bajwa authorized prescriptions for alprazolam and Adderall when Patient P should not have needed a refill of these medications had she taken them as prescribed, as follows:

Date Rx Written	Medication Dose/Quantity	Days Supply Per PMP Report	Date Previous Rx
2/22/18	Adderall 20mg #30	30	2/2/18 (from another provider) Adderall ER 30mg #30 30-day supply
4/7/18	alprazolam 2mg #33	11	3/19/18 30-day supply
6/11/18	Adderall 30mg #30	10	6/5/18 (from another provider) Adderall ER 20mg #30 30-day supply
6/11/18	Adderall 30mg #60	30	6/5/18 (from another provider) Adderall ER 20mg #30 30-day supply
7/6/18	alprazolam 2mg #90	30	6/11/18 30-day supply
7/31/18	alprazolam 2mg #90	30	7/6/18 30-day supply
7/31/18	Adderall 30mg #30	10	7/12/18 40-day supply
7/31/18	Adderall 30mg #60	20	7/12/18 40-day supply
9/7/18	alprazolam 2mg #90	30	9/2/18 (from another provider) alprazolam 1mg #42 14-day supply

iv. Dr. Bajwa increased the strength and/or quantity of alprazolam and Adderall he prescribed Patient P on March 16, 2018, March 19, 2018, April 17, 2018, and April 19, 2018, at the patient's request, without any therapeutic indication for doing so documented in the medical record. Patient P told the Department of Health Professions Investigator (Investigator) that because she was a Medicaid recipient, her monthly Adderall 30mg was limited to #60 (60mg/day), the maximum recommended daily dose. In order to avoid the Medicaid limit and obtain Adderall 30mg #90 (90mg/day) monthly, Patient P stated that she paid Dr. Bajwa cash for a "third" prescription at each visit and then paid out of pocket for the extra medication at the pharmacy.

v. Had Dr. Bajwa responded to Patient P's obvious drug seeking behavior, he might have learned that Patient P was admitted to several hospitals with various combinations of suicidal

ideation, psychoses, and hallucinations on May 21, 2018, June 17, 2018, September 15, 2018 (pursuant to a Temporary Detention Order (TDO)), and October 13, 2018 (pursuant to a TDO), related to her consumption of benzodiazepines and Adderall.

b. Regarding Patient Q, a then 21-year-old male, who Dr. Bajwa treated from approximately June 2017 through August 2018:

i. Absent a comprehensive psychiatric evaluation including a substance use history and risk assessment or documentation of symptoms or findings supporting a therapeutic purpose, Dr. Bajwa prescribed alprazolam 1mg #30 (30-day supply) at the patient's first office visit on June 1, 2017, based solely on the patient's report of anxiety with panic attacks. At the same visit, Dr. Bajwa prescribed hydrocodone-chlorpheniramine ER #120 (12-day supply) based on the patient's complaint of a cough that kept him "up at night," without documenting a comprehensive physical exam or any explanation supporting an opioid as the appropriate treatment for a cough.

ii. Although Dr. Bajwa stated in his written response to the Board that he prescribed to Patient Q based on the patient's response to the medication, Dr. Bajwa doubled the alprazolam to 2mg on June 21, 2017, without any documentation of the patient's response, i.e., symptoms, triggers, or presentation, etc., and simply documented that the patient reported "1mg not effective." Dr. Bajwa steadily increased Patient Q's alprazolam to 2mg #90 (30-day supply) on August 28, 2017, without any documentation explaining his decision to exceed the manufacturer's recommended daily dose (4mg/day).

iii. Although Patient Q was absent from Dr. Bajwa's practice for approximately three months, Dr. Bajwa resumed prescribing alprazolam 2mg #90 (30-day supply) on February 2, 2018, noting that the patient was stable with medications, without any documentation regarding the patient's absence or the performance of any physical or mental examination.

c. Regarding Patient R, a then 20-year-old female, who Dr. Bajwa treated from approximately December 2017 through August 2018:

i. At Patient R's first visit on December 8, 2017, Dr. Bajwa prescribed alprazolam 2mg #90 (30-day supply), a dose exceeding the manufacturer recommended maximum daily dose (4mg/day), based on the patient's self-report of anxiety and claim that "She needs it 3x per day." Dr. Bajwa failed to obtain or document a detailed substance use or medical history or description of symptoms. Further, Dr. Bajwa failed to verify that the patient had taken alprazolam previously and if so, at what dose. Although Dr. Bajwa claimed in his statement to the Board that he checked the patient's PMP report at each visit, the PMP Access Audit records show that he did not access Patient R's PMP report at any time while treating her.

ii. At Patient R's January 9, 2018 visit, Dr. Bajwa documented that the patient "wants med for ADHD," and had the patient complete an Adult ADHD-Rating-Scale-IV tool used as one part of a comprehensive ADHD work-up. Without conducting a comprehensive physical or mental examination or documenting any assessment as to whether the patient's symptoms were clinically consistent with a diagnosis of ADHD, Dr. Bajwa prescribed Adderall 20mg #60 (30-day supply) to the patient for ADHD on that date.

d. Regarding Patient S, a then 19-year-old female, who Dr. Bajwa treated from June 2018 through July 2018:

i. Absent a comprehensive psychiatric evaluation, including a substance use history and risk assessment, or documentation of symptoms or findings supporting a therapeutic purpose, Dr. Bajwa prescribed alprazolam 2mg #60 (30-day supply) at the patient's first office visit on June 18, 2018, based solely on the patient's report of anxiety with panic attacks.

ii. At Patient S's next visit on July 5, 2018, Dr. Bajwa increased the patient's

alprazolam to TID based on the patient's claim that she needed an extra pill to control the anxiety, absent any documentation in the medical record supporting his decision to exceed the manufacturer's recommended daily dose (4mg/day). Moreover, Dr. Bajwa admitted to the Investigator that he discussed the patient seeing a psychiatrist, but the patient only wanted Dr. Bajwa to treat her anxiety, and he did not recommend any other alternative or concomitant treatments.

e. Regarding Patient T, a then 24-year-old male, who Dr. Bajwa treated from approximately February 2017 to March 2017:

i. Dr. Bajwa prescribed alprazolam 1mg #60 (30-day supply) at Patient T's first visit on February 17, 2017 based on the patient's self-report of anxiety and having taken alprazolam 1mg in the past, without documenting a comprehensive examination or obtaining a detailed substance use history.

ii. At Patient T's second and final visit with Dr. Bajwa on March 9, 2017, in addition to increasing the alprazolam to 2mg based only on the patient's report that 1mg "was not effective," Dr. Bajwa prescribed promethazine with codeine syrup for the patient's complaints of congestion and mild wheezing keeping him "up at night," without documenting a comprehensive physical exam or any explanation supporting an opioid as the appropriate treatment for a cough.

7. Dr. Bajwa violated Virginia Code § 54.1-2915(A)(3), (12), (13), (16), and (18) and 18 VAC 85-20-26(C) of the Board's General Regulations, in that from approximately January 2014 through October 2018, he failed to maintain timely, accurate, and complete medical records for Patients A-T. For example:

a. Although the complete medical records Dr. Bajwa produced to the Board for Patient D contain a new patient registration form dated April 1, 2009, and lab results and other testing listing Dr. Bajwa as the ordering physician dated back to 2010-2011, the office progress notes date back only to May

19, 2014.

b. Although the complete medical records Dr. Bajwa produced to the Board for Patient E contain a new patient registration form dated December 30, 2009, the office progress notes produced date back only to June 5, 2014.

c. Although the complete medical records Dr. Bajwa produced to the Board for Patient F contain a new patient registration form dated January 24, 2011, the office progress notes produced date back only to January 28, 2014.

d. The hand-written progress notes for Patients A-T are often identical for multiple patients, and are repetitive over time with little or no changes in chief complaint, symptoms, review of systems, and physical examination. For example, the physical examinations in support of opioid prescribing to treat low back pain for Patients B, C, F, J, K, L, and N all document, "moderate tenderness over lower lumbar paraspinous muscles."

e. Although Dr. Bajwa prescribed multiple controlled substances with high abuse potential to Patients A-T, he had no signed medication management contracts with any patient, nor did he conduct any UDS' or pill counts on Patients A-T during the prescribing period. In fact, Dr. Bajwa told the Investigator that UDS monitoring is "only for pain patients taking opiates."

f. The complete medical records for Patients A-T produced by Dr. Bajwa lack critical, relevant medical information to the care he was providing, including, for example, medication lists; complete vital signs; weight; plans of care; records of telephone consults, contacts, prescription authorizations; and/or complete problem lists.

8. Dr. Bajwa violated Virginia Code § 54.1-2915(A)(4) in that he is incompetent to practice medicine and surgery with safety to his patients and the public, as evidenced by his care and treatment of Patients A-T between 2014 and 2018, as detailed above in Allegations 1-7.

See Confidential Attachment for the names of the patients referenced above.

[redacted]

for William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

4/5/19
Date